

# mattison

www.MattisonPodiatryGroup.com

DRS. SUSAN & BRAD MATTISON

podiatry  
group



561.364.5522  
561.364.9828

Where feet come first.

## We welcome you as our patient!

**Please Print.**

Today's Date \_\_\_\_\_

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_

Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Home Address \_\_\_\_\_

Northern Address \_\_\_\_\_

EMERGENCY CONTACT: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Referred to our office by \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_

Previous podiatry visit(s) (When/Why?) \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

### **Please note the following:**

If you have health insurance, please give the receptionist your insurance card and your photo ID so we can copy them and place them in your file. If we are approved providers under your plan, you will be responsible for co-pays, deductibles, and any other non-covered services at the time of your visit. If you do not have health coverage, payment is expected in full at time of service unless other arrangements have been made prior to your visit. Please inquire prior to treatment if you have any questions.

*I hereby authorize Dr. Mattison and Mattison Podiatry Group to assign benefits on my behalf, and I authorize the release of any medical records necessary to obtain payment from my insurance company.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

EAST BOYNTON BEACH LOCATION  
3695 Boynton Beach Blvd, Suite 4 Boynton Beach, FL 33436

WEST BOYNTON BEACH LOCATION  
7280 Boynton Beach Blvd, Suite 200 Boynton Beach, FL 33437

